TARGETED CASE MANAGEMENT STANDARDS

STATEMENT	COMPONENTS	DATA SOURCE	EVALUATION CRITERIA	EXCEPTIONS	REFER/RECOMMEND
Case management services should be available to all clients enrolled in or eligible for prenatal care, family planning, preventive child health care & WIC. **I. Case Management:** **The System:** A. A comprehensive written strategy for the provision of case management services should be developed by each provider of health services for women, children and their families.	The strategy for providing case management services should include: A. A description of case management services provided by the agency; B. Information on how clients will access health and human services; C. A description of how the agency will coordinate case management initiatives with other public and/or private health care providers in the community; D. Methods to reduce barriers to services by providing the client and family assistance in: 1. completing applications, 2. scheduling appointments, 3. arranging for transportation; E. Methods to provide case management services in locations convenient to the client such as: 1. clinic sites nearest the client's home, 2. other service delivery sites nearest the client's home, 3. the client's home;	Agency Manual Case Management Plan Provider application for Targeted Case Management (TCM).	The provider has developed written comprehensive strategy for the provision of case management services that includes protocols on how to provide the services. The agency provides flexible times (evenings and Saturdays) for appointments. The agency coordinates services with other service providers to maximize the multi-disciplinary problem solving and reduce duplication.		

STATEMENT	COMPONENTS	DATA SOURCE	EVALUATION CRITERIA	EXCEPTIONS	REFER/RECOMMEND
	F. Method to conduct ongoing community needs assessments and resource linkages; and G. A method of evaluating the strategy**.**		Community needs assessments include all service providers in the community to enhance interdisciplinary collaboration.		
B. The case management provider shall develop and/or maintain an integrated case management system based upon their comprehensive written strategy.	The development and maintenance of a case management system should include : A. Initiation and maintenance of cooperative agreements with service providers within the area to include: 1. the TDH Region, 2. local health departments, 3. other health providers, 4. other case management providers, 5. social service providers, 6. transportation providers; B. Initiation and maintenance of a working relationship with local community and governmental entities; C. The development/ maintenance and annual update of referral resources which includes, but is not limited to: 1. prenatal services, 2. family planning services, 3. preventive child health services, 4. WIC, 5. ECI,	A. Agreements with other providers TMC application and/or contract B. Agency records such as meetings agendas, memos, minutes, etc. C. Referral resource system	A. There are written agreements regarding the scope of services with other case management providers. B. There is evidence of ongoing working relationships with other entities. The agency participates regularly in community coalitions**.** C. There is a current comprehensive directory of available resources which includes names, addresses, and telephone numbers**.**	If unable to obtain actual written agreements, copies of letters to agencies stating the concept of case management and the intent to be TCM providers should be on file.	

STATEMENT	COMPONENTS	DATA SOURCE	EVALUATION CRITERIA	EXCEPTIONS	REFER/RECOMMEND
	6. CIDC, 7. rehabilitative services, 8. social services, 9. primary care, 10. physicians, 11. hospitals, 12. a tertiary center; and				
II. Case Management: The Service Case management services to the client/family must include the following components: A. Initial Intake	The initial intake consists of an initial contact with the client or parent(s), in the case of a child, to determine the client's eligibility and/or need for case management services. It includes a preliminary needs assessment and a determination of whether or not the client/parent(s) desires to receive case management services. The risk assessment/initial intake may be done at any site where the client/family accesses the system. It is preferable it be completed by a licensed social worker or registered nurse.	Client record	There is documentation of initial intake preferably by a registered nurse or licensed social worker	The client/family always has a right to refuse or to limit the scope of case management services.	When possible, the initial intake should be completed with another activity such as the comprehensive needs assessment**.**
B. Comprehensive needs assessment	A. The comprehensive needs assessment is conducted by a case manager during a face-to-face interview with the client/parent(s) and involves an evaluation of at least the following:	Client record	There is documentation of a comprehensive needs assessment which was conducted in a face-to-face interview by a qualified case manager.	The client/family always has the right to refuse or to limit the scope of case management.	The comprehensive needs assessment may require a home visit to complete.

STATEMENT	COMPONENTS	DATA SOURCE	EVALUATION CRITERIA	EXCEPTIONS	REFER/RECOMMEND
	1. medical/health needs; 2. social/family needs; 3. nutritional needs; 4. educational/vocational needs; 5. developmental needs (for infants, children); 6. health care transportation needs; and 7. capacity of client to assume own case management activities. B. The process includes a review of formal evaluations conducted by other professional, i.e. medical specialist, developmental centers, educational evaluation.	Client record	There is documentation of review, by other professionals of evaluations, if applicable.		The family may act as the case manager. Any reports relevant to client or family may be considered. Through a joint staffing and based on the family's needs and available options, a single comprehensive case manager should be determined. This does not preclude the family from having one or more specialized case managers, whose focus is the individual and whose involvement with the family will be limited to a single program or service.
C. Service Plan Implementation	The service plan is developed during a face-to-face contact between the case manager & the client/parent(s). It addresses all of the client's specific needs identified in the needs assessment. The plan: 1. establishes priorities among the client's needs; 2. includes measurable goals to be achieved through the provision of services, which	Client Record	There is documentation of a completed service plan. The plan reflects the priorities and involvement of the family. The client/parent's signature appears on the service plan. The plan reflects interdisciplinary collaboration.		

STATEMENT	COMPONENTS	DATA SOURCE	EVALUATION CRITERIA	EXCEPTIONS	REFER/RECOMMEND
	include client empowerment; 3. outlines the responsibilities of: a. the case manager, b. the client/parent(s), c. the family, d. other pertinent person; 4. incorporates the plans of other involved professionals; 5. provides information and direction so as to empower the client to access and utilize needed services; and 6. includes a monitoring schedule.				
D. Service Plan Implementation	The case manager implements the plan and works with the client/parent(s) to ensure that services are located and obtained. Services are coordinated with multiple providers as necessary. A medical home is identified for each client**.**	Client record	There is documentation of service plan implementation and interdisciplinary charting. The documentation reflects a problem solving orientation that empowers the family.		
E. Monitoring/Service Plan Review	A. The case manager monitors the service plan to determine: 1. what services have or have not been delivered. 2. were services delivered as scheduled; and 3. whether services were consistent with the plan. 4. whether modifications to the service plan or a change of service provider(s) are required.	Client record	There is documentation of monitoring contacts by the case manager either face-to-face or by phone. Documentation reflects client empowerment through increased skill and capacity of self care. There is documentation of the reason for alteration of the monitoring schedule**.**	Client terminates case management services. Unable to locate client/family after three attempts, one of which was a home visit**.**	Collaboration with all members of the team is essential.

STATEMENT	COMPONENTS	DATA SOURCE	EVALUATION CRITERIA	EXCEPTIONS	REFER/RECOMMEND
	B. The recommended monitoring schedule unless modified for client/family needs is: 1. monthly during pregnancy, within five days postpartum, within one month postpartum, and then as indicated; 2. during the first two weeks after hospital discharge for high risk infants, and monthly thereafter				
F. Reassessment	A formal reassessment of the client's/family's needs and progress toward's meeting those needs is conducted in face-to-face contact by the case manager with the client/family. Modifications to the plan are made as necessary. A decision as to whether or not case management should continue is made with the client/family. A reassessment should be conducted at least once during the pregnancy or postpartum period, and at least once during an infant's first year of life.	Client record	There is documentation of reassessment by the case manager and all the team members. Record reflects client satisfaction. Records reflects client satisfaction.		The formal reassessment should be done in a face-to-face contact. An interdisciplinary staffing is recommended. Client satisfaction surveys should be utilized at regular intervals.

STATEMENT	COMPONENTS	DATA SOURCE	EVALUATION CRITERIA	EXCEPTIONS	REFER/RECOMMEND
III. Case management services should be provided by qualified case managers who may be assisted by community service aides and other personnel.	A. A case manager should be: 1. a Texas licensed, registered nurse with a minimum of one year experience in community health nursing; or 2. a Texas licensed social worker with a minimum of one year experience in health and/or human services.	Agency administrative records	There is evidence of a TCM 90-day training certificate, documentation of appropriate education, qualifications, and appropriate supervision of all case management staff.		
	B. A community service aide is an individual who may receive a TDH 90-day training orientation to case management. She/he assists the case manager in the provision of case management services. She/he is supervised by the case manager in the performance of her/his case management duties. The aide assists with: 1. outreach; 2. community and client education; 3. completing application forms; 4. arranging needed appointments/services; 5. Tracking activities; and 6. home contact for non-therapeutic intervention.	Agency administrative records and client record.	There is documented evidence in the record that the CSA is supervised by the case manager.	There is a certificate that documents that the CSA has received the TCM 90-day training.	

STATEMENT	COMPONENTS	DATA SOURCE	EVALUATION CRITERIA	EXCEPTIONS	REFER/RECOMMEND
IV. The case management provider must be involved with community education / outreach.	The community education/ outreach should: A. Inform the community regarding the availability and value of maternal and child health services to include: case management services, preventive services such as: prenatal care, family planning, child health/Texas Health Steps (EPSDT), WIC, ECI, and CIDC; B. Inform the community about health care issues;	Agency records Targeted case management application, contract.	There is a community education/outreach plan and documentation of community education activities**.**		Emphasize integrated services with target populations.
STATEMENT	**COMPONENTS**	**DATA SOURCE**	**EVALUATION CRITERIA**	**EXCEPTIONS**	**REFER/RECOMMEND**
	C. Develop liaisons with schools, churches, community groups, etc.; and D. Provide outreach services in a client's own environment, i.e. schools, homes, businesses, etc.				

STATEMENT	COMPONENTS	DATA SOURCE	EVALUATION CRITERIA	EXCEPTIONS	REFER/RECOMMEND
V. The case management provider must have an ongoing evaluation/quality assurance system in place regarding case management services.	The system should: A. Monitor the case management services and outcome indicators, i.e. 1. new client intake; 2. cumulative case load; 3. appointment compliance; 4. resources utilized; and 5. system development 6. periodic chart review; 7. observation of case managers supervisor's notes. B. Monitor quality services: 1. periodic chart reviews; 2. observation of case management staff/client-family; 3. client-family interviews or questionnaires. C. Monitor interdisciplinary collaboration to include: 1. interdisciplinary charting; 2. documentation of staff consultations.	Agency records Automated reporting systems as available Client records Clients records Observation tools Completed client satisfaction surveys Employee evaluations Client record	There is evidence that case management is integrated as part of an existing and ongoing quality assurance program in the agency. 10% of records reviewed per quarter		

STATEMENT	COMPONENTS	DATA SOURCE	EVALUATION CRITERIA	EXCEPTIONS	REFER/RECOMMEND
VI. The case management provider should have an ongoing continuing education program for their personnel.	The continuing education program should include: A. An orientation to case management for nurses, social workers, other professionals, community service aides and other personnel;	Agency records	There is an ongoing staff development plan that includes: 1. all case management staff providing Targeted Case Management services have attended a TCM 90-day training orientation. 2. professional staff are supported and encouraged to obtain continuing education.		Case management staff are encouraged to attend interdisciplinary workshops or programs in other professional areas.
	B. A mechanism for the evaluation and identification of ongoing case management education needs among staff; C. Plans for scheduling staff attendance at appropriate workshops, seminars, etc., on an ongoing basis; and D. Plans for scheduling training in-house on an ongoing basis.	Self evaluation tool			Case management staff are encouraged to attend interdisciplinary workshops or programs in other professional areas.

Revised 5/7/98